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|---|---|---|---|
| | 155291 | A. BUILDING 01<br>B. WING | 11/21/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| EAGLE VALLEY MEADOWS | 3017 VALLEY FARMS RD<br>INDIANAPOLIS, IN46214 |

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| K0000 | A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).<br><br>Survey Date: 11/21/11<br><br>Facility Number: 000188<br>Provider Number: 155291<br>AIM Number: 100266310<br><br>Surveyor: Mark Caraher, Life Safety Code Specialist<br><br>At this Life Safely Code survey, Eagle Valley Meadows was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.<br><br>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 115 and had a census of 103 at the time of this survey. | K0000 | The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk review in lieu of a post survey review on or after 12/16/11. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| | Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/23/11.<br><br>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following: | | | |
| K0018 SS=E | Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3<br><br>Roller latches are prohibited by CMS regulations in all health care facilities.<br>Based on observation and interview, the facility failed to ensure 1 of 2 Rehabilitation Dining Room doors protecting corridor openings did not have an impediment to the closing of the door. This deficient practice could affect any resident, staff or visitor in the vicinity of the Rehabilitation Dining Room.<br><br>Findings include: | K0018 | **K 018** It is the practice of this provider to ensure doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substanial doors, such as those constructed of 1 3/4 inch solid-bonded core wood or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors | 12/16/2011 |

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| | Based on observation with the Maintenance Director during a tour of the facility from 11:10 a.m. to 1:15 p.m. on 11/21/11, the west door to the Rehabilitation Dining Room was held in the open position with a door stop at the bottom of the door. Based on interview at the time of observation, the Maintenance Director acknowledged the west door to the the Rehabilitation Dining Room was held open with a doorstop.<br><br>3.1-19(b) | | are provided with a means suitable for keeping the door closed. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>·The Maintenance Dircector removed the door stop from the Rehabilitation dining room door on 11/22/11.<br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>·All residents have the potential to be affected by this deficient practice.<br>**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?**<br>·The Maintenance Director/designee to remove all non-compliant door stops by 12/16/11.<br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what qualityassurance program will be put into place?**· The Maintenance Supervisor/designee will complete the Life Safety Review CQI weekly for four weeks, monthly for three months and quarterly thereafter. · Safety Committee to review audit results for compliance. If threshold of | |

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| | | | 90% not met an action plan will be created. | |
| K0029 SS=E | One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1<br>Based on observation and interview, the facility failed to ensure 1 of 11 doors serving hazardous areas such as the kitchen latch into the door frame. This deficient practice could affect any resident, staff or visitor in the vicinity of the kitchen.<br><br>Findings include:<br><br>Based on observation with the Maintenance Director during a tour of the facility from 11:10 a.m. to 1:15 p.m. on 11/21/11, the kitchen door by the service corridor is equipped with a self closing device and a positive latching mechanism but the kitchen door failed to latch into the door frame because the door would not completely close. Based on interview at the time of observation, the Maintenance Director stated the door | K0029 | **K 029** It is the practice of this provider to ensure one-hour fire rated construction or an approved automatic fire extinguishing system protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted.<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>·The kitchen door by the service corridor was corrected so the door would close and latch into the doorframe by the Maintenance Director on 11/22/11. | 12/16/2011 |

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| | would not close completely because the threshold was elevated and acknowledged the kitchen door by the service corridor would not latch into the door frame.<br><br>3.1-19(b) | | **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>·All residents who use the main dining room have the potential to be affected by this deficient practice.<br>**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?**<br>·The Maintenance Director and or designee will monitor to ensure that all doors can close monthly. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? · The Maintenance Supervisor and or designee will complete the fire drill report monthly to ensure doors close. Data collected will be submitted to the CQI Committee for review and follow-up If threshold of 90% is not met a plan of correction will be completed. | |

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| K0050 SS=F | Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2<br>Based on record review and interview, the facility failed to document fire drills conducted on the third shift for 1 of 4 quarters. This deficient practice affects all occupants in the facility including residents, staff and visitors.<br><br>Findings include:<br><br>Based on review of "Monthly Fire Drill Report" documentation with the Maintenance Director during record review from 9:20 a.m. to 11:10 a.m. on 11/21/11, there is no documentation available for review for a fire drill conducted on the third shift for the third quarter of 2011. Based on interview at the time of record review, the Maintenance Director stated a fire drill was conducted on the third shift in the third quarter 2011 but acknowledged there was no documentation available for review of a fire drill being conducted on the third shift for the third quarter of 2011. | K0050 | **K 050** It is the practice of this provider to hold file drills that are unexpected at times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drils are part of established routine. Responsibility for planning and conducting drlls is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9pm and 6 am a coded announcement may be used instead of audible alarms. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>·A fire drill was conducted by the Maintenance Supervisor on the third shift on 12/13/11.<br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>·All residents have the potential | 12/16/2011 |

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| | 3.1-19(b) | | to be affected by this deficient practice.<br>**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?**<br>·The Maintenance Director/designee will hold fire drills quarterly on each shift.<br>·The Fire drill - Shift/ Time Stagger schedule will be followed by the Maintenance Supervisor.<br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br>· The Fire Drill - Shift/Time Stagger schedule will be reviewed monthly by the Executive Director and signed off for compliance. · Safety Committee to review fire drill results monthly. | |
| K0062 SS=E | Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5<br>Based on observation and interview, the facility failed to replace 5 of 5 sprinklers in the laundry room which had a buildup of lint and dust on each sprinkler head. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and | K0062 | **K 062**<br>It is the practice of this provider to ensure that the required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically.<br>**What corrective action(s) will** | 12/16/2011 |

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| | Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect residents, staff and visitors in the vicinity of the laundry room.<br><br>Findings include:<br><br>Based on observation with the Maintenance Director during a tour of the facility from 11:10 a.m. to 1:15 p.m. on 11/21/11, all five automatic sprinklers in the laundry room had a buildup of lint and dust on each sprinkler head. Based on interview at the time of observation, the Maintenance Director acknowledged the laundry room sprinkler heads had a buildup of lint and dust on each sprinkler head.<br><br>3.1-19(b) | | **be accomplished for those residents found to have been affected by the deficient practice?**<br><br>·The 5 sprinlker heads were dusted and checked for damage or corrosion by the Maintenance Director on 11/22/11.<br><br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br><br>·All residents have the potential to be affected by this deficient practice.<br><br>**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?**<br><br>·The Maintenance Director/designee will complete weekly and monthly checks on the sprinkler system according preventative maintenance schedule.<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br><br>· The Executive Director will | |

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| | | | review the preventative maintance schedule with the Maintenance Director weekly for four weeks and monthly thereafter.<br><br>· Safety Committee to review audit results for compliance. If threshold of 90% not met a plan of action to be completed. . | |
| K0076 SS=E | Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.<br><br>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.<br><br>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4<br>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage locations of greater than 3000 cubic feet was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction. This deficient practice could affect any resident, staff or visitor in the vicinity of the oxygen storage and transfilling room.<br><br>Findings include:<br><br>Based on observation with the | K0076 | **K 076** It is the practice of this provider to ensure that medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. Oxygen storage locations of greater than 3000 cu. ft. are enclosed by a one hour spearation. Locations for supply systems of greater than 3000 cu. ft. are vented to the outside. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>·The ceiling was removed in the oxygen room and replaced with | 12/16/2011 |

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| | Maintenance Director during a tour of the facility from 11:10 a.m. to 1:15 p.m. on 11/21/11, the oxygen storage and transfilling room contained six liquid oxygen canisters and the ceiling for the room had one layer of five eighths inch thick drywall. Based on interview at the time of observation, the Maintenance Director acknowledged the ceiling did not provide 1 hour fire resistive construction for the oxygen storage and transfilling room.<br><br>3.1-19(b) | | two layers of 5/8" thick fire-coded drywall by the Maintenance Director on 12/13/11.<br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>·All residents have the potential to be affected by this deficient practice.<br>**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?**<br>·The Maintenance Director/designee will monitor the oxygen room for compliance.<br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br>· The Maintenance Supervisor/designee will complete the Life Safety Review CQI weekly for four weeks, monthly for three months and quarterly thereafter. · Safety Committee to review audit results for compliance. If threshold of 90% not met an action plan will be created. | |

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| K0143 SS=E | Transferring of oxygen is:<br><br>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;<br><br>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and<br><br>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2<br>Based on observation and interview, the facility failed to ensure 1 of 1 liquid oxygen storage areas where transferring of oxygen takes place was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction. This deficient practice could affect residents, staff and visitors in the vicinity of the oxygen storage and transfilling room.<br><br>Findings include:<br><br>Based on observation with the Maintenance Director during a tour of the facility from 11:10 a.m. to 1:15 p.m. on 11/21/11, the oxygen storage and transfilling room is posted with a sign stating "Oxygen Transfer in Progress" and contained six liquid oxygen canisters. | K0143 | **K 0143** It is the practice of this provider to ensure that the transferring of oxygen is (a) separated from any portion of a facility wherein patients are housed, examined or treated by a separation of a fire barrier of 1-hour fire-resistive construction;(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and(c)in an area posted with signs indicating that transferrring is occurring and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association.**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>·The ceiling was removed in the oxygen room and replaced with two layers of 5/8” thick fire-coded | 12/16/2011 |

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| | The ceiling for the oxygen storage and transfilling room consists of one layer of five eighths inch thick drywall. Based on interview at the time of observation, the Maintenance Director acknowledged the ceiling did not provide 1 hour fire resistive construction for the oxygen storage and transfilling room.<br><br>3.1-19(b) | | drywall by the Maintenance Director on 12/13/11.<br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>·All residents have the potential to be affected by this deficient practice.<br>**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?**<br>·The Maintenance Director/designee will monitor the oxygen room for compliance.<br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br>· The Maintenance Supervisor/designee will complete the Life Safety Review CQI weekly for four weeks, monthly for three months and quarterly thereafter. · Safety Committee to review audit results for compliance. If threshold of 90% not met an action plan will be created. | |
| K0144 SS=F | Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.<br>1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with | K0144 | **K 076**It is the practice of this provider to ensure that generators are inspected weekly and exercised under load for 30 | 12/16/2011 |

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| | a remote manual stop. NFPA 99, Health Care Facilities, 3-4.1.1.4 requires generator sets installed as alternate power sources shall meet the requirements of NFPA 110, Standard for Emergency Standby Power Systems. NFPA 110, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break glass station located outside of the room where the prime mover is located. NFPA 110, 7-1 states NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, contains mandatory requirements for emergency generators and shall be considered part of the requirements of this standard. NFPA 37, 8-2.2(c) requires emergency generators of 100 horsepower of more have provisions for shutting down the engine at the engine and from a remote location. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on observation with the Maintenance Director during a tour of the facility from 11:10 a.m. to 1:15 p.m. on 11/21/11, a remote shut off device was not found for the 155 kW diesel fired emergency generator. A sticker attached to the nameplate for the generator stated | | minutes per month in accordance with NFPA 99. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**<br>·A remote shut off device was added to the emergency generator on 12/1/11 by Indiana Power Service and Supply.<br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>·All residents have the potential to be affected by this deficient practice.<br>**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?**<br>·The Maintenance Director/designee will complete the Emergency Generator Weekly Exercise/Monthly Load test log weekly and monthly according to the preventative mainteance schedule.<br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**<br>· The Executive Director will review the Emergency Generator Weekly Exercise/Monthly Load test log weekly for four weeks and monthly thereafter to ensure compliance. · Safety Committee | |

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| | 155291 | A. BUILDING 01<br>B. WING | 11/21/2011 |

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| | the "date put in service" was 01/07/81. Based on interview at the time of observation, the Maintenance Director acknowledged there is no remote emergency shut off device for the emergency generator.<br><br>3.1-19(b)<br><br>2. Based on record review and interview, the facility failed to provide complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.1.1.8 requires the generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on review of "Emergency Generator-Weekly Exercise/Monthly Load Test Log" documentation with the Maintenance Director during record review from 9:20 a.m. to 11:10 a.m. on 11/21/11, the emergency generator was run on a monthly basis for at least thirty minutes each month for the period of | | to review audit results for compliance. If threshold of 90% not met an action plan will be created. | |

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| | 01/11/11 through 06/28/11 but the logs utilized by the facility did not record the time to transfer power from the main source to each emergency generator. Based on interview at the time of record review, the Maintenance Director acknowledged the transfer time to transfer power to each emergency generator was not recorded for each month for the period of 01/11/11 through 06/28/11.<br><br>3.1-19(b)<br><br>3. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted for 4 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:<br>a. Under operating temperature conditions or at not less than 30 percent of the EPS | | | |

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| | nameplate rating.<br>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.<br>The date and time of day for required testing shall be decided by the owner, based on facility operations. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on review of "Emergency Generator-Weekly Exercise/Monthly Load Test Log" documentation with the Maintenance Director during record review from 9:20 a.m. to 11:10 a.m. on 11/21/11, monthly load test documentation was not available for review for the period of July 2011 through October 2011. Based on interview at the time of observation, the Maintenance Director acknowledged there was no documentation available for review for the period of July 2011 through October 2011.<br><br>3.1-19(b) | | | |

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| | 4. Based on record review and interview, the facility failed to ensure a complete written record of weekly inspections of the starting batteries for the emergency generator was maintained for 16 of 52 weeks. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on review of "Emergency Generator-Weekly Inspection Checklist" documentation with the Maintenance Director during record review from 9:20 a.m. to 11:10 a.m. on 11/21/11, weekly emergency generator starting battery | | | |

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| | inspection records for the four week period in February 2011 and the twelve week period from 07/01/11 through 10/31/11 was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged documentation of weekly battery inspections for the four week period in February 2011 and the twelve week period from 07/01/11 through 10/31/11 was not available for review.<br><br>3.1-19(b) | | | |